

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of \$8,901.00 for dates of service 04/11/01 through 06/11/01.
- b. The request was received on 05/28/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA(s)
 - c. TWCC 62 forms
 - d. Reimbursement data
 - e. Medical Records
 - f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II: No response found in the case file.
3. Based on Commission Rule 133.307 (g) (4), the Division notified the insurance carrier Austin Representative of two copies of additional information 07/24/02. The Respondent did not submit a response to the request. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.
4. A letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 05/22/02.

"As (Provider) has reported, this documentation conclusively indicates that the average rate (Provider) is reimbursed for its chronic pain management services is \$104.98, or 84% of the billed rate of \$125 per hour. This average rate established by the market forces is also in accordance with the new Medical Fee Guidelines effective September 1, 2002.

The Commission is[sic] has passed a rate of \$100.00 per hour for non-CARF accredited multidisciplinary, chronic pain programs (134.202 (e)(5)(E). Clearly, the Commission recognizes the complexity and intensity of these services and has determined their rate more in line with what (Provider) has found to be the market average rate of reimbursement.”

2. Respondent: No response found in the dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 05/30/01 and extending through 06/11/01. Any dates of service prior to 05/28/01 are not within the TWCC’s jurisdiction per Rule 133.307(d)(1).
2. The explanation of denial listed on the EOBs is, “AFFL C-BASED ON THE REPORTED FEDERAL TAX IDENTIFICATION (TIN), REIMBURSED IN ACCORDANCE WITH (INSURANCE CARRIER). F-THE PROCEDURE CODE IS REIMBURSED BASED ON THE MEDICAL FEE SCHEDULE. IF ONE IS NOT MANDATED, THE UCR ALLOWANCE IS REIMBURSED FOR THE ZIP CODE AREA.”
3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
05/30/01	97799-CP	\$937.50 (6.25 units)	\$480.00	F	DOP	TWCC Act & Rules Sec. 413.011 (d), Rules 133.304 (i) & 133.307(D)(1) (G)(3)(1) MFG;MGR (II)(C)(G)	<p>The provider has included in their dispute packet, documentation (EOBs from other carriers) that provides some evidence of “fair and reasonable” reimbursement per Sec. 413.011(d). The provider is a non-CARF accredited facility, therefore billed amount will be reduced 20% according to the Fee Guidelines. The carrier did not respond to this dispute. The provider billed in accordance with the referenced Rule and medical documentation indicates that the services were rendered. No evidence of a methodology was submitted as required by Rule 133.304(i).</p> <p>The provider billed an hourly rate of \$150.00 for the services rendered. The carrier reimbursed the provider an average of \$75.00 an hour.</p> <p>The provider has submitted reimbursement data, from other carriers, that indicates they have been willing to accept \$100.00 an hour, for CPT code 97799-CP. This is the fee after the 20% reduction, due to non-CARF accreditation, from \$125.00 of the billed services, for non-CARF accredited facilities.</p> <p>The Medical Review Division must review the evidence submitted to determine which party has provided the most persuasive evidence to support fair and reasonable since there is no MAR. The carrier has failed to submit a response or a methodology. The provider has submitted some evidence of fair and reasonable.</p> <p>Therefore, based on the evidence of fair and reasonable, submitted by the provider, indicating \$100.00 is an acceptable rate. Reimbursement is recommended in the amount of \$925.00. (\$25.00 x 37.0 hours billed = \$925.00).</p>
06/01/01		\$937.50 (6.25 units)	\$480.00	F			
06/04/01		\$937.50 (6.25 units)	\$480.00	F			
06/06/01		\$937.50 (6.25 units)	\$480.00	F			
06/08/01		\$862.50 (5.75 units)	\$400.00	F			
06/11/01		\$937.50 (6.25 units)	\$480.00	F			
Totals		\$5,550.00	\$2,800.00				The Requestor is entitled to reimbursement in the amount of \$925.00 .

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$925.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3rd day of February 2003.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb